XIV. Regulatory Impact Analysis

A. General

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Public Law 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

The statutory effects of the provisions that would be implemented by this proposed rule result in expenditures exceeding $100 million per year. We estimate the total impact of these changes for CY 2002 payments compared to CY 2001 payments to be approximately a $450 million increase. Therefore, this proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status of by having revenues of $5 to $25 million or less annually (see 65 FR 69432). For purposes of the RFA, all providers of hospital outpatient services are considered small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds, or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent

NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals.

It is clear that the changes in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a regulatory impact analysis.

Section 202 of the Unfunded Mandate Reform Act of 1995 (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that

it will not have any negative impact on the rights, roles, and responsibilities of State, local or tribal governments.

B. Changes in this Proposed Rule

We are proposing several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(8)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2002. We are also proposing revisions to the relative APC payment weights based on claims data from July 1, 1999 through June 30, 2000. Finally, we are proposing to begin calculating outlier payments on an APC-specific basis rather than the current method of calculating outlier payments for each claim.

The projected aggregate impact of updating the conversion factor is to increase total payments to hospitals by 2.3 percent. As described in the preamble, budget neutrality adjustments are made to the conversion

factor and the weights to assure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. In addition, the determination of the parameters for outlier payments have been modified so that projected outlier payments for 2002 are equivalent to the established policy target of 2.0 percent of total payments. Because we are not revising the target percentage, there is no estimated aggregate impact from modifying the method of determining outlier payments.

The impact of the wage, recalibration and outlier changes do vary somewhat by hospital group. Estimates of these impacts are displayed on Table 6.

C. Limitations of our Analysis

The distributional impacts represent the projected effects of the proposed policy changes, as well as statutory changes effective for 2002, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

D. Estimated Impacts of this Proposed Rule

Column 5 in Table 6 represents the full impact on each hospital group of all the changes for 2002. Columns 2 through 4 in the table reflect the independent effects of the proposed change in the wage index, the APC reclassification and recalibration changes and the change in outlier method, respectively.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that would experience a negative impact due to wage index changes are those in the Middle Atlantic and Pacific Regions, a decrease of 0.3 percent for each. Conversely, the urban hospitals are generally negatively affected by these changes, with the largest effect on those with 500 or more beds (0.6 percent decrease) and those in the Middle Atlantic (1.7 percent decrease) and West South Central Regions (1.5 percent decrease).

We estimate that the APC reclassification and recalibration changes have generally an opposite impact from the wage index, causing increases for all urban hospitals except those with under 200 beds and volumes of fewer than 21,000 services per year and those located in the New England (a 0.1 percent decrease), Middle Atlantic (a 0.7 percent decrease), East North Central (a 0.55

percent decrease), and Puerto Rico (a 5.6 percent decrease) Regions.

The change in outlier policy to an APC-specific payment has a slight negative effect on rural hospitals as a group (a 0.2 percent decrease), no effect on urban hospitals as a group, and slight negative effects on all smaller hospitals as well as those with lower volumes of services.

The overall projected increase in payments for urban hospitals is slightly greater (2.4 percent) than the average increase for all hospitals while the increase for rural hospitals is somewhat less than the average increase (1.9 percent). Rural hospitals gain 1.2 percent from the wage index change, but lose a combined 1.7 percent from the APC changes and the change in method of determining outlier payments.

In both urban and rural areas, hospitals that provide a higher volume of outpatient services are projected to receive a larger increase in payments than lower volume hospitals. In rural areas, hospitals with volumes of fewer than 5000 services are projected to experience a small decline in payments (-0.1 percent). The less favorable impact for the low volume hospitals is attributable to the APC changes and the change in outlier method. For example,

rural hospitals providing fewer than 5000 services are projected to lose a combined 3 percent due to these changes.

Urban hospitals in the Middle Atlantic region are projected to receive no increase in payments, and we estimate a decline of 0.1 percent for rural hospitals in this region. Both the urban and rural hospitals lose 2.4 percent due to the wage index change and APC changes. The urban hospitals are affected more by the wage index change (-1.7 percent), while rural hospitals are affected more by the recalibration (-2.1 percent). Urban hospitals in the East South Central Region are projected to experience the largest increase in payments (5.5 percent).

Major teaching hospitals are projected to experience a smaller increase in payments (1.3 percent) than the aggregate for all hospitals due to negative impacts of the wage index (-0.7 percent), recalibration (-0.1 percent), and outlier changes (-0.2 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.0 percent) that is larger than the average for all hospitals. This is attributable to the fact that there is no impact on this group for the wage index change and positive impacts for both the APC changes (0.6 percent) and outlier changes (0.1). There is little

difference in impact among hospitals with varying shares of low-income patients.

Table 6-- Impact of Changes for CY 2002 Hospital Outpatient Prospective Payment System

TABLE 6.
Impact of Changes for CY 2002 Hospital Outpatient Prospective Payment System
Percent changes in total payments (program and beneficiary)

	Number of hospitals /1	New wage index /2	APC recalib. /3	New outlier policy /4	All CY 2002 changes /5
	(1)	(2)	(3)	(4)	(5)
ALL HOSPITALS	5,077	0.0	0.0	0.0	2.3
NON-TEFRA HOSPITALS	4,701	0.0	0.0	0.0	2.3
URBAN HOSPS	2,608	-0.3	0.4	0.0	2.4
LARGE URBAN (GT 1 MILL.)	1,495	-0.5	0.1	0.0	1.9
OTHER URBAN (LE 1 MILL.)	1,113	-0.1	0.7	0.1	3.1
RURAL HOSPS	2,093	1.2	-1.5	-0.2	1.9
BEDS (URBAN)					
0 - 99 BEDS	661	0.0	-1.9	-0.1	0.3
100-199 BEDS	918	-0.3	-0.4	0.1	1.8
200-299 BEDS	510	-0.3	0.6	0.0	2.6
300-499 BEDS	374	-0.3	1.1	0.1	3.2
500 + BEDS	145	-0.6	1.1	0.0	2.7
BEDS (RURAL)					
0 - 49 BEDS	1,249	0.4	-2.4	-0.6	-0.2
50- 99 BEDS	506	0.7	-2.2	-0.2	0.6
100- 149 BEDS	198	1.6	-0.7	0.0	3.2
150- 199 BEDS	74	1.6	-1.0	-0.1	2.8
200 + BEDS	66	2.6	-0.2	0.1	4.8
VOLUME (URBAN)					
LT 5,000	363	-0.5	-0.5	-0.3	1.0
5,000 - 10,999	496	-0.3	-1.1	0.0	0.9
11,000 - 20,999	605	-0.4	-0.4	0.1	1.7
21,000 - 42,999	746	-0.4	0.6	0.1	2.6
GT 42,999	398	-0.2	0.6	0.0	2.7
VOLUME (RURAL)					
LT 5,000	1,000	0.4	-2.0	-1.0	-0.1

5,000 - 10,999	569	0.5	-2.3	-0.2	0.2
11,000 - 20,999	322	1.1	-1.7	-0.1	1.6
21,000 - 42,999	171	1.7	-0.9	0.0	3.0
GT 42,999	31	2.8	-0.3	0.0	4.8
REGION (URBAN)					
NEW ENGLAND	136	1.0	-0.1	-0.2	3.0
MIDDLE ATLANTIC	380	-1.7	-0.7	0.0	0.0
SOUTH ATLANTIC	429	0.4	1.3	0.1	4.1
EAST NORTH CENT.	444	-0.4	-0.5	0.1	1.5
EAST SOUTH CENT.	154	1.3	1.8	0.1	5.5
WEST NORTH CENT.	183	-0.1	0.2	0.1	2.5
WEST SOUTH CENT.	323	-1.5	1.6	0.0	2.3
MOUNTAIN	129	0.1	1.2	0.0	3.6
PACIFIC	391	-0.2	0.4	0.0	2.5
PUERTO RICO	39	1.2	-5.6	-0.2	-2.3
REGION (RURAL)					
NEW ENGLAND	51	0.4	-2.3	-0.4	0.0
MIDDLE ATLANTIC	72	-0.3	-2.1	0.1	-0.1
SOUTH ATLANTIC	276	1.8	-0.8	-0.1	3.2
EAST NORTH CENT.	275	1.5	-2.5	-0.1	1.2
EAST SOUTH CENT.	250	1.5	-0.9	-0.1	2.8
WEST NORTH CENT.	501	1.3	-2.1	-0.3	1.2
WEST SOUTH CENT.	326	1.4	-0.2	-0.2	3.2
MOUNTAIN	200	1.6	-1.1	-0.5	2.4
PACIFIC	137	-0.3	-1.2	-0.2	0.6
PUERTO RICO	5	4.2	-3.1	-0.3	3.0
TEACHING STATUS					
NON-TEACHING	3,594	0.2	-0.4	0.0	2.1
MINOR	812	0.0	0.6	0.1	3.0
MAJOR	294	-0.7	-0.1	-0.2	1.3
DSH PATIENT PERCENT					
0	27	0.0	-1.1	-0.7	0.7
GT 0 – 0.10	1,298	-0.1	-0.3	0.0	2.0
0.10 - 0.16	1,047	0.2	-0.2	0.1	2.3
0.16 - 0.23	822	-0.1	0.3	0.0	2.5
0.23 - 0.35	812	0.1	0.2	0.0	2.6
GE 0.35	695	-0.2	0.1	-0.3	2.0
URBAN IME/DSH					
IME & DSH	1,012	-0.4	0.5	0.0	2.4
IME/NO DSH	4	-0.1	-2.2	-1.2	-1.0
NO IME/DSH	1,578	-0.2	0.2	0.1	2.4
NO IME/NO DSH	14	0.1	0.9	0.7	4.0
RURAL HOSP. TYPES					
NO SPECIAL STATUS	797	0.5	-2.0	-0.2	0.6
RRC	171	2.3	-0.5	0.1	4.2
SCH/EACH	656	0.7	-2.2	-0.4	0.5
MDH	327	0.2	-2.5	-0.5	-0.4
SCH AND RRC	70	2.1	-0.9	-0.1	3.4
TYPE OF OWNERSHIP					

VOLUNTARY	2,808	-0.1	-0.1	0.0	2.2
PROPRIETARY	761	0.0	0.9	0.2	3.4
GOVERNMENT	1,132	0.4	-0.4	-0.2	2.1
SPECIALTY HOSPITALS					
EYE AND EAR	12	0.1	-8.3	0.6	-5.3
TRAUMA	154	-0.2	-0.1	-0.1	1.9
CANCER	10	-1.7	2.3	-1.6	1.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES)					
REHAB	164	-1.8	10.0	-1.0	8.9
PSYCH	88	-1.4	-0.6	-3.5	-3.1
LTC	83	-0.7	-2.3	-0.2	-1.0
CHILDREN	41	-0.6	-2.0	-2.2	-2.2

[1] Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.
[2] This column shows the impact of updating the wage index used to calculate payment using the proposed FY 2002 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient proposed rule for FY 2002 was published in the Federal Register on May 4, 2001.
[3] This column shows the impact of recalibrating the APC weights based on 1999-2000 hospital claims data and of the reassignment of some HCPCs to APCs as discussed in this rule.
[4] This column shows the difference in calculating outliers on an APC-specific rather than bill basis.
[5] This column shows changes in total payment from CY 2001 to CY 2002. It incorporates all of the changes reflected in columns 1, 2, 3, and 4. In addition, it shows the impact of the CY 2002 payment update and of changes in pass-through payments from CY 2001 to CY 2002. The sum of the columns may be different from the percentage changes shown here due to rounding.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.